**File number ..... – CONFIDENTIAL - A.A. .....**

RADIOMARATHON FOUNDATION FOR CHILDREN WITH SPECIAL NEEDS

PHYSIOTHERAPY ***REASSESSMENT*** FORM

**Therapist Name: ..... Register number.....**

**PRIVATE: Address ..... Tel. ……..**

**Date: Evaluation: .....**

**Child's Name: ..... Date of birth. ……**

**A. REASSESSMENT RESULTS / GENERAL REMARKS: .....**

**.....**

**.....**

**B. OBJECTIVES: .....**

**.....**

**.....**

**Reassessment Date: .....**

**C. OBSERVANCE OF PHYSIOTHERAPY MEETINGS: Attended ..... times in .....planned treatments.**

**D. OTHER TREATMENTS AND THEIR FREQUENCY:**

**Physiotherapy ..... times a week**

**Speech therapy..... " " "**

**Occupational therapy..... " " "**

**Hydrotherapy..... " " "**

**Special Education..... " " "**

**Psychol. Support..... " " "**

**Name of therapist: ..... Signature: .....**

**Date:** ……